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Job Turnover of Hospital CEOs

Evaluating Innovative Curricula

Computers in Academic Medicine

- Databases in the Basic Sciences
- A Computer Workstations Project
- Evaluating Instructional Software
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Teaching Agenda in Research Ethics

Evaluating Residents

Views of Educational Needs

Volunteer Community Preceptors

Practitioners' Career Changes

VOLUME 65 • NUMBER ONE

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JOURNAL OF THE
ASSOCIATION OF
AMERICAN MEDICAL
COLLEGES

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Publishing Services: Hanley & Belfus, Inc.
210 South 13th Street, Philadelphia, PA 19107

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Subscription rates: U.S., Canada, Latin America—$60.00 per year and $7.00 per single copy ($30.00 per year for students); all other locations—$70.00 per year and $8.00 per single copy.

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Manuscripts: The Editor, *Academic Medicine*, Association of American Medical Colleges, One Dupont Circle, NW, Washington, DC 20036.

Advertising: Diane Sherel, Advertising Manager, Hanley & Belfus, Inc., 210 South 13th Street, Philadelphia, PA 19107; (215) 546-0313.
Subscriptions and changes of address: Membership and Publication Orders, AAMC, One Dupont Circle, NW, Washington, DC 20036.
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INVITED ARTICLE

PETER A. WEIL, Ph.D.

Job Turnover of CEOs in Teaching and Nonteaching Hospitals

Abstract—Using data published annually by the American Hospital Association, this research compares the turnover rates of chief executive officers (CEOs) at approximately 800 teaching and approximately 4,700 nonteaching hospitals. (In this study, teaching hospitals were all hospitals with any reported affiliation with a medical school. About half of the hospitals studied had a major commitment to teaching, with several residency programs and a substantial number of residents in each program.) For each year studied (1981–1987), the teaching hospital CEOs experienced less turnover than did nonteaching hospital CEOs. While the turnover of CEOs from nonteaching hospitals showed a linear increase each year, culminating at 25.2% in 1987, the turnover of CEOs from teaching hospitals showed a more erratic pattern, resulting in 18.7% that year. A group of hospitals was identified that accounted for a large proportion of all recent CEO turnover. For example, 16% of the teaching hospitals experienced two or more CEO turnovers between 1981 and 1986. But these "higher-turnover" hospitals accounted for almost half of all teaching hospital turnovers. The higher-turnover hospitals were disproportionately found among non-federal government hospitals, in regions outside the Midwest, and in large cities; these hospitals also experienced higher costs per patient day and lower operating margins than did the lower-turnover hospitals. The research suggests that turnover may be accounted for, in part, by the comparative performance of a hospital relative to other hospitals of its type. Thus, whether hospitals experience stable, increasing, or declining operating margins, the higher-turnover hospitals typically underperform relative to other hospitals. *Acad. Med.* 65(1990):1–7.

Increasingly we hear about hospitals whose CEOs leave their posts—sometimes after many years of service—and we may wonder why there is so much turnover at the top. To study this problem in detail, three organizations[1] came together to begin a thorough study of CEO turnover. The first phase of the study, already completed, describes the extent of hospital CEO turnover over a six-year period, the kinds of hospitals experiencing higher numbers of turnovers, characteristics of the CEOs who left, and where they went.[1] The next phase of the study is currently under way; its objective is to develop a greater understanding of the reasons underlying CEO turnover.

CEO turnover is usually regarded as a negative phenomenon. It creates a short-term crisis in some hospitals because it interrupts the normal flow of activities, and many projects are put off until the new CEO is appointed. Not only do many hospitals spend a lot of time, effort, and money to find a suitable replacement, but other positions often will be vacated as the new CEO brings in a new team.

Of course, the departing CEO may feel angry, betrayed, or humiliated. Often the loss of the job means family displacement and financial pressure. Turnover often prevents CEOs from realizing their vision of where the hospital should be going, and it can short-circuit their careers.

But CEO turnover can bring positive outcomes for both the hospital and the CEO. For the hospital, it provides opportunities to think about new directions, and about developing new relationships with other providers, purchasers, government officials, and the community at large. It also provides the opportunity to abandon old unsuccessful strategies and bury hatchets from previous battles.

For many executives, too, turnover can mean a step up to a more challenging hospital CEO position, or it can lead to a shift to a non-hospital position with new and interesting challenges. For some it represents an opportunity to take a less demanding position; for others, it represents a time for career closure and a leisure-oriented lifestyle.[2]

A certain amount of CEO turnover is necessary and good. One of the opportunities this study provided was to identify hospital industry norms and to track these patterns over time. In this article, I focus on three questions.

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One: What are the recent CEO turnover rates at teaching and nonteaching hospitals?

Two: Is there such a thing as a "higher-turnover" hospital—a hospital that can't seem to hold onto its CEO for long?

Three: What are some of the distinguishing characteristics of CEOs who leave their positions?

I conclude by suggesting what part of the total turnover phenomenon I think is caused by a "ripple effect" as CEOs are recruited to other CEO slots, and speculate about some of the other possible causes of hospital CEO turnover.

Sources of Data

To answer the first question of the study, I used data from a six-year period, 1981–1987; to answer the second, I used data from a five-year period, 1981–1986. All these data were collected by the American Hospital Association and published in its annual *Guide to the Health Care Field*,[3] a comprehensive listing of the nation's hospitals. CEO turnover was denoted when the reported name of the administrator changed from one year to the next. This method of reporting understates turnover when there is more than one CEO change in a year.

To investigate the third question, I also used the biographical database of the American College of Healthcare Executives (hereafter referred to as "the College") for the years 1981 and 1987. This society is the largest professional association of healthcare executives, three-fourths of whom are hospital administrators; over half the hospital CEOs in the United States belong to the College.

I restricted the analysis regarding the first two questions to short-term, general medical and surgical, and non-federal-government hospitals. In these categories, the teaching hospitals were defined as hospitals having any affiliation with a medical school. There were 801 such hospitals in 1986–87. (About half of these had a major commitment to teaching, with several residency programs and a substantial number of residents in each program.) During the same year, there were 4,724 nonteaching hospitals in the categories previously mentioned.

However, slightly smaller numbers of both teaching and nonteaching hospitals are reported when I describe the higher- and lower-turnover hospitals in the Results section of this article. This is because it was necessary to study trends in hospital CEO turnover over a period of years (1981–1986) in order to examine the second question (whether there is a "higher-turnover" hospital); hospitals that failed to report the name of the CEO or that were not listed in each of the years studied were excluded from the analysis.

I examined the following hospital characteristics to try to distinguish the higher-turnover hospitals from the lower-turnover ones: bedsize, membership in a hospital system, type of ownership, region in which the hospital was located, size of the community where the hospital was located, level of admissions, occupancy rate, cost per patient day, and operating margin.

Prediction Difficulties

For a variety of reasons, it is difficult to predict the turnover rates of CEOs at teaching and nonteaching hospitals. On the one hand, several factors argue for teaching hospitals to experience higher CEO turnover rates than their nonteaching counterparts. First, most teaching hospitals serve a high proportion of poor and uninsured patients.[4] This would leave them open to financial losses and consequent dissatisfaction with management. Second, some teaching hospitals have full-time medical staffs—people who are powerful, entrenched, and tenured. Obviously, when crossed—for whatever reason—their clout might very well prevail over that of the executive, who may have an employment contract but is not tenured. Third, CEOs in around half the teaching hospitals in this study's sample are pledged to pursue a complicated mission: teaching, research, and patient care. Juggling these three key objectives while keeping the hospital financially solvent may require superhuman abilities.

But several other features of teaching hospitals argue for their CEOs to enjoy less turnover than their counterparts in nonteaching hospitals. First, unlike nonteaching hospitals, Medicare has allowed them certain cost adjustments—notably a 7.5% allocation for teaching costs, for the inefficiencies necessarily introduced in the teaching process, and for the severity of illnesses experienced by patients there. So when nonteaching hospitals are totally at the mercy of prospective payment, teaching hospitals have a little compensation for their higher costs. Second, because many medical staffs in major teaching hospitals are employed full-time, they have ample opportunity to interact with executives, are themselves aware of the difficulty of administering departments and the various services, and are strongly invested in the hospital's well-being. Ultimately, these physicians may feel less alienated from hospital executives and may indeed support them to a greater extent than would physicians in nonteaching settings.

Third, the very complexity of the teaching hospital's mission makes the evaluation of managers difficult. Thus, by dint of the near-impossibility of fulfilling all three objectives of teaching, research, and patient care, managers might be given an overall favorable evaluation even if they may have performed below expectations in some areas. Fourth, teaching hospitals often are larger; their operating margins tend to be higher than those of nonteaching hospitals.[5] Analogous studies of school superintendents showed that those in larger districts were less likely to experience turnover than were those in small districts.[6] Finally, boards of trustees of larger hospitals are more likely to use predetermined criteria for selecting as well as evaluating the CEO; thus there might be fewer board-initiated terminations.[7]

When I considered the kinds of individuals who are the CEOs of teaching hospitals compared with the CEOs in nonteaching hospitals, my experience led me to predict that the

teaching hospital CEOs would be at the pinnacle of their careers, would have more experience in health administration, and would be older. Consequently, their leaving might be for the purpose of retirement. On the other hand, nonteaching hospital CEOs might be on their way to greater challenges and thus more likely to move on to a different hospital. Thus, because the two types of hospitals could represent different stages in the careers of CEOs, it is impossible to predict what impact individual differences of CEOs might have on overall turnover rates.

Findings

The findings concerning the three questions of this study were highly illuminating and suggest that turnover may be as much a product of the general hospital context in which CEOs are located as it is a product of CEOs' personal career plans.

One: CEO Turnover Rates

Figure 1 shows that the 749 teaching hospitals for which adequate data were available experienced lower rates of CEO turnover every year for the six years of the study than did the 4,539 nonteaching hospitals for which there were data. Also, an erratic pattern is evident for teaching hospital CEOs. After a significant increase between 1981 and 1982, the turnover rate actually decreased between 1983 and 1985, only to rise sharply in the most recent time period. However, the year-to-year trends within the teaching hospitals are not as statistically stable as is true for the nonteaching group, since they are based on data from a smaller group of hospitals.

For both the teaching and the nonteaching hospitals, the biggest single-year increase in turnover was during the 12-month period immediately before the introduction of the prospective payment system (that is, from 1981–82 through 1982–83). The average annual rate of increase for the last five years studied was 2.3% for the teaching hospitals; for the nonteaching hospitals, it was 4.9%.

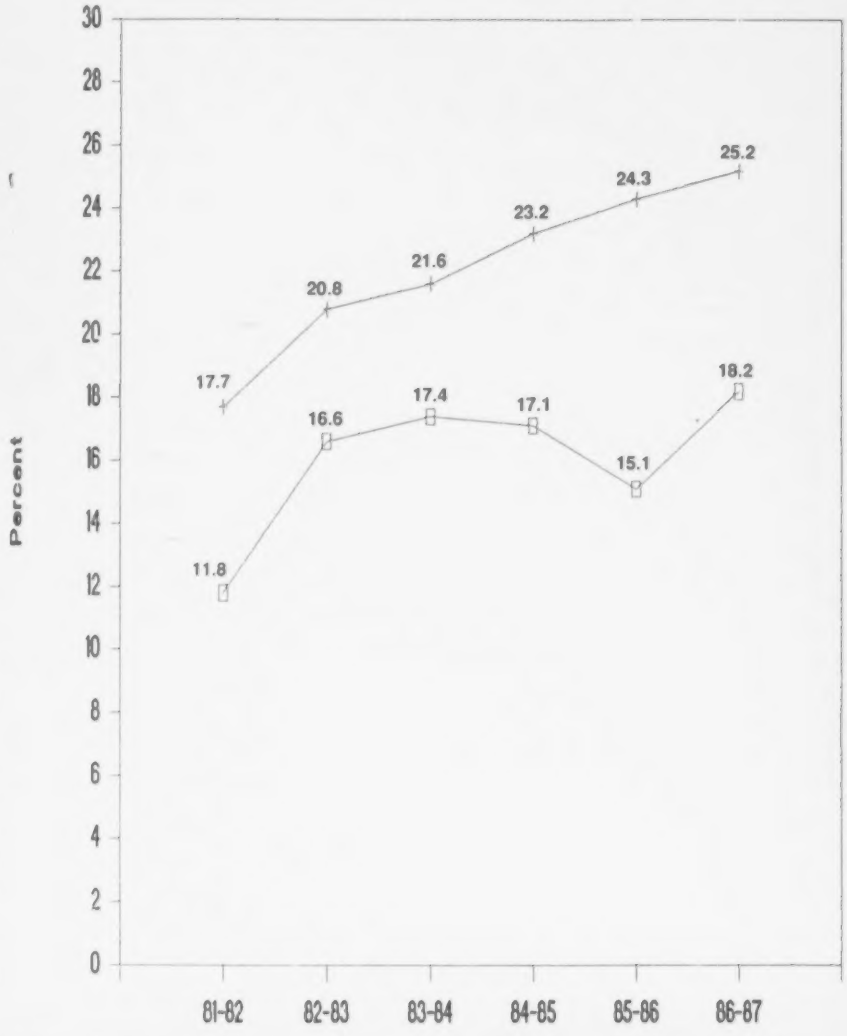

Figure 1. **Job turnover of chief executive officers in 749 U.S. teaching hospitals and 4,539 nonteaching hospitals, 1981–1987. Teaching hospitals were defined as those having any degree of affiliation with a medical school. For both the teaching and the nonteaching hospitals studied, the biggest single-year increase in turnover was during the 12-month period from 1981–82 through 1982–83, which was the time immediately before the introduction of the prospective payment system. Average annual rates of increase for the last five years studied were 2.3% for the teaching hospitals and 4.9% for the nonteaching hospitals. *Rectangles* represent teaching hospitals; *crosses* represent nonteaching hospitals.**

Two: "Higher-Turnover" Hospitals

One advantage of looking at turnover for a period of years is identifying hospitals with higher rates of turnover. Using the data from the American Hospital Association, I examined hospital turnover for each year between 1981 and 1986. (As already noted, the hospitals that failed to report the name of the CEO or that were not listed in each of the five years were excluded from the analysis concerning the second question of this study.) Hospitals were classified into three groups: those with no turnover in the five-year period, those with one turnover, and those with two

or more turnovers. Hospitals with no turnover or with one turnover were designated "lower-turnover" hospitals, while those experiencing two or more turnovers were labeled "higher-turnover" hospitals.

1. A small percentage of hospitals accounted for most hospital CEO turnover. In the five-year period beginning in 1981–82 and ending in 1985–86, approximately 46% of all teaching hospitals had no CEO turnover, while 38% of them experienced one change in the CEO position. What is critical is that 16% of the hospitals that experienced two or more turnovers—the higher-turnover teaching hospitals—accounted for 49% of all turnovers.

Among the nonteaching hospitals, a similar pattern prevailed. Between 1981–82 and 1986–87, 37% experienced no CEO turnovers, 36% had one turnover, and 27%—the higher-turnover nonteaching hospitals—had two or more turnovers. This last group—the higher-turnover nonteaching hospitals—accounted for 64% of all turnovers.

While both a percentage of both the teaching and the nonteaching hospitals were composed of higher-turnover hospitals, a notable difference between the two groups was that the higher-turnover hospitals were a smaller proportion of the teaching group than they were of the nonteaching group. The implication: getting a CEO job in a teaching hospital means that the CEO is less likely to change jobs. The chances of a CEO's leaving a position in a higher-turnover teaching hospitals were one in six during the years studied, but in nonteaching hospitals, these same chances were about one in four.

2. CEOs were much more likely to experience turnover in the higher-turnover hospitals. What did serving in higher- or lower-turnover hospitals mean to the careers of hospital CEOs? There was a 50% probability that CEOs at the helms of higher-turnover hospitals (whether teaching or nonteaching) would leave their organizations in the following year, making their average tenure only two years.

In contrast, executives who headed lower-turnover teaching hospitals had only a 9% probability of leaving in the following year, giving them an average tenure of 11 years. CEOs in lower-turnover nonteaching hospitals had a 10% probability of leaving in the following year, giving them an average tenure of ten years.

3. All nine hospital characteristics used in this study helped distinguish the higher-turnover nonteaching hospitals from those with lower turnover. Listed in the following paragraphs are the nine hospital characteristics that served to identify where the CEO turnover rates in nonteaching hospitals were higher. The nine variables were determined to be statistically significant ($p < .05$) using chi-square tests for categorical variables and analysis of variance for continuous variables.

SMALLER HOSPITALS. From 1981 to 1986, smaller hospitals experienced higher turnover. In 1986, for example, the nonteaching hospitals with no turnover averaged 137 beds. The hospitals with one turnover had an average of 130 beds, while those with two or more turnovers had an average size of 109 beds. Stated another way, 73% of the hospitals with fewer than 50 beds had two or more turnovers, compared with 19% of hospitals with over 400 beds.

SYSTEM HOSPITALS. Thirty-six percent of the nonteaching hospitals that were part of a system had higher turnover. In contrast, only 19% of the nonteaching hospitals that were freestanding experienced higher turnover, a factor that may be due in part to intrasystem promotions or reassignments.

INVESTOR-OWNED HOSPITALS. Between 1981 and 1986, 49% of the nonteaching investor-owned hospitals experienced two or more CEO turnovers. This compares with 22% of the not-for-profit church hospitals, 21% of the not-for-profit secular hospitals, and 27% of the state and local government-owned hospitals that were higher-turnover hospitals.

HOSPITALS IN THE SOUTH AND WEST. Higher turnover among nonteaching hospitals was concentrated in the West—37% of the hospitals had two or more turnovers in the five-year period—and in the South, where 31% of the hospitals were higher-turnover ones.

HOSPITALS IN THE LARGEST CITIES. The hospitals located in cities above 156,000 population experienced higher turnover. Thirty-six percent of the hospitals in the 100 largest cities had two or more CEO turnovers. In contrast, small cities had the lowest percentage of higher turnover—averaging 22%. About 27% of the higher-turnover hospitals were in nonmetropolitan and suburban sites.

HOSPITALS WITH LOWER ADMISSIONS. Between 1981 and 1986, the nonteaching hospitals with lower admissions experienced higher turnover. In 1986, for example, the hospitals with no turnover averaged 4,566 admissions, and the hospitals with one turnover experienced 4,132 admissions. The hospitals with more turnovers averaged only 3,188 admissions.

HOSPITALS WITH LOWER OCCUPANCY RATES. The nonteaching hospitals with higher turnovers had occupancy rates 7% lower than the occupancy rates of the hospitals with no turnover between 1981 and 1986. In 1986, for example, the hospitals with no turnover had an average occupancy rate of 55%; those with one turnover averaged 52%. But higher-turnover hospitals averaged 48% that year.

HOSPITALS WITH HIGHER COSTS. Again, a consistent pattern was seen for the higher-turnover hospitals to experience higher costs than those experienced by other, lower-turnover hospitals. For example, in 1986 the average total cost per patient day for the no-turnover hospitals was $410; for the one-turnover hospitals it was $436. But the higher-turnover hospitals averaged $467 per day.

HOSPITALS WITH LOWER OPERATING MARGINS. Using unpublished data

from the American Hospital Association, Figure 2 shows the operating margins for nonteaching hospitals by CEO turnover status. For each year between 1982 and 1987, a gradient appears. The highest operating margins are in the zero-turnover hospitals, the next-highest margins are in the one-turnover hospitals, and the lowest margins are in the hospitals that experienced two or more turnovers between 1981 and 1986.

4. Only five hospital characteristics used in this study helped distinguish the higher-turnover teaching hospitals from those with lower turnover. The useful characteristics were ownership, region, size of community, costs, and operating margin. Listed in the following paragraphs are the five hospital characteristics that served to identify where CEO turnover rates in teaching hospitals were higher. These variables were determined to be statistically significant by using the same statistical procedures previously described for the nonteaching hospitals.

NON-FEDERAL GOVERNMENT HOSPITALS. Between 1981 and 1986, 24% of the non-federal government hospitals experienced higher turnover, compared with 11% of the not-for-profit church hospitals and 17% of the not-for-profit secular hospitals.

HOSPITALS OUTSIDE THE MIDWEST. The higher-turnover teaching hospitals tended to lie outside the midwestern region, where only 11% had multiple CEO turnovers between 1981 and 1986. In contrast, the higher-turnover hospitals constituted 18% of hospitals in the Northeast, 18% of the hospitals in the West, and 20% in the South.

HOSPITALS IN LARGE CITIES. The higher-turnover hospitals were concentrated in the largest cities (over 156,000 population), where they constituted 21% of all hospitals studied. They represented only 11% of the hospitals in smaller cities, 14% of those in suburban areas, and 15% of the hospitals in nonmetropolitan areas.

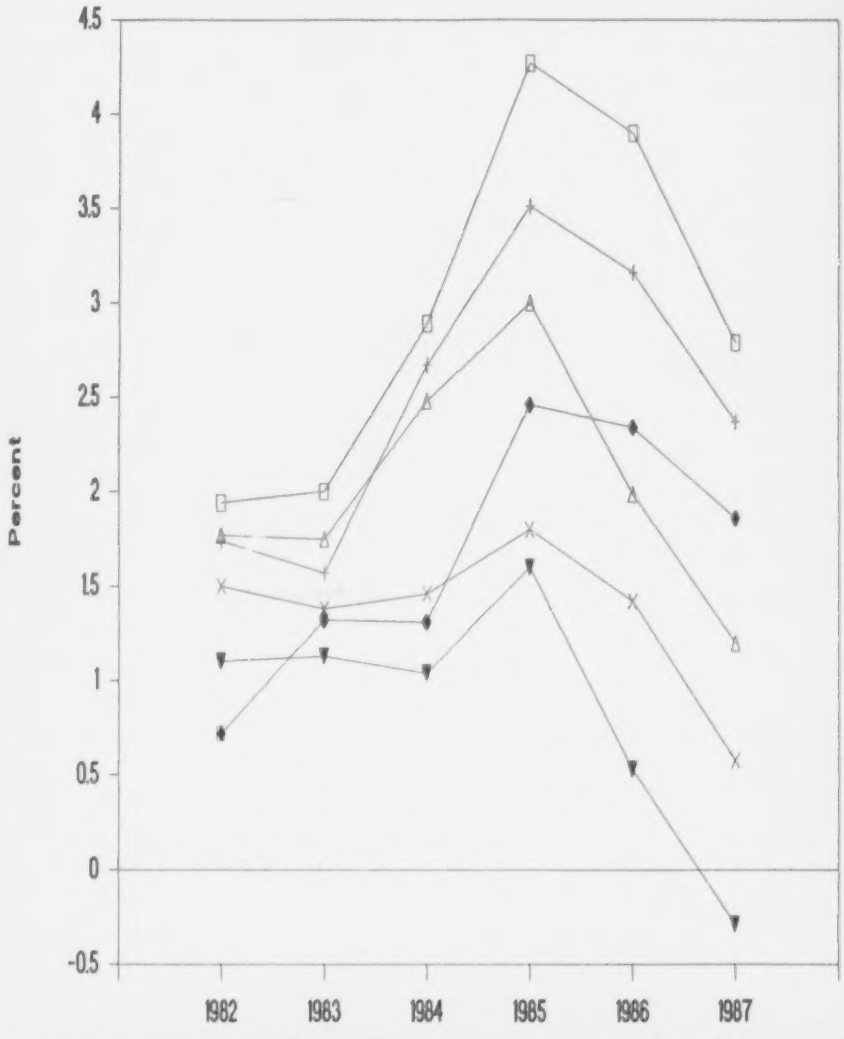

Figure 2. **A comparison of the median operating margins and job turnovers of chief executive officers (CEOs) in 749 U.S. teaching hospitals and 4,539 nonteaching hospitals, 1981–1986, and 729 teaching and 4,452 nonteaching hospitals in 1987. Teaching hospitals were defined as those having any degree of affiliation with a medical school. After 1985, both groups of hospitals experienced declining operating margins; however, the teaching hospitals with two or more CEO turnovers experienced a lower rate of decline in operating margins than did any other type of hospital. Also, consistent with their lower turnover rates, the teaching hospitals had higher operating margins than did the nonteaching hospitals. Hollow symbols indicate no CEO turnover in teaching hospitals (*rectangles*) and nonteaching hospitals (*triangles*). Line symbols indicate one CEO turnover in teaching hospitals (*crosses*) and nonteaching hospitals (*Xs*). *Solid symbols* indicate two or more CEO turnovers in teaching hospitals (*diamonds*) and nonteaching hospitals (*inverted triangles*).**

HOSPITALS WITH HIGHER COSTS. From 1981 to 1986 the hospitals with higher costs per patient day experienced higher turnover. For the hospitals with no CEO turnover during the same time period, the average total cost per patient day was $546 in 1986; for those with one turnover, the aver-

age total cost was $570. But teaching hospitals with two or more turnovers produced the highest average cost: $587.

HOSPITALS WITH LOWER OPERATING MARGINS. As was true for the nonteaching hospitals, a gradient in operating margin appeared for each year (1982–1987) between the hospitals with zero, one, and two or more CEO turnovers. The highest margins were seen in zero-turnover hospitals; the lowest margins were in the two-or-more-turnover hospitals. After 1985, when operating margins peaked, each type of hospital experienced declining operating margins. However, the teaching hospitals with two or more CEO turnovers experienced a lower rate of decline than did any other type of hospital. (See Figure 2.) Also, consistent with their lower turnover rates, the teaching hospitals had higher operating margins than did the nonteaching hospitals. Tests of differences between means showed significantly lower operating margins between the two-or-more-turnover hospitals and others in all cases except for teaching hospitals in 1983 and 1986.

To control for the fact that many of these variables were interrelated, I conducted an ordinary least-squares regression analysis. Variables that were statistically (at $p<.10$ or less) significant in predicting being a higher-turnover teaching hospital were metropolitan location, membership in a multihospital system, and low occupancy rate. Also, being under not-for-profit church auspices is negatively related to being a higher-turnover teaching hospital. The volatility of the mean operating margin probably accounts for its insignificance as a predictor. Instead, low occupancy rate is significantly associated with teaching hospitals that experience high CEO turnover.

Three: CEO Characteristics

Even though certain hospitals seem to experience CEO turnover more than others, turnover is experienced by an individual as well. To help identify whether specific types of individuals are more susceptible to turnover, the existing database of the American College of Healthcare Executives ("the College") was used. That database includes a comprehensive biography of approximately half of the nation's hospital CEOs.

The College is disproportionately composed of CEOs of larger (over 200 beds), not-for-profit, general medical, surgical, and children's hospitals, as well as hospitals that are system members. In addition, these executives are more heavily represented in the nation's teaching hospitals, metropolitan areas, and the New England, Middle Atlantic, and East North Central regions.

Using the College's database for the years 1981 and 1987, it became clear that turnover of hospital CEOs in 1987 was different than it had been as recently as 1981. In 1981, for example, turnover was higher among younger executives, people under age 35 who had been in their positions for less than the median period of CEO service (4.25 years, a relatively short period). But today, turnover is being experienced by executives in all age groups and, in fact, is slightly higher among CEOs who have been in their positions longer than average. (College-affiliated CEOs have about the same tenure today as they did in 1981. Then, the mean tenure for departing CEOs was 7.1 years; in 1987, it was 6.5 years.)

The data indicate that the CEOs who left their positions in 1987 early (that is, before the median period of 4.25 years) not only could be any age, but had the following characteristics: (1) they more often than not were unmarried, (2) they were not involved in preceptorships—that is, taking on residents in health administration, (3) they had short tenures in their previous positions, and (4) they had served as CEOs in locations other than their birthplaces.

On the other hand, it was difficult to characterize the CEOs who left after relatively long (more than 4.25 years) tenures. The data indicated no important differences between them and those who stayed on, including demographic, career, and hospital characteristics.

A real advantage of studying this subgroup of hospital CEOs from the College data is to obtain some estimate of how much turnover occurs within their own ranks. In 1987, 40% of the College CEOs who left their positions as heads of hospitals moved to become CEOs of other hospitals (30.5%) or CEOs of hospital systems (9.5%). This gives a new slant to the turnover statistics presented earlier, since it tells us that turnover in hospitals creates a ripple effect. For instance, in 1987 academic hospitals experienced an 18.2% turnover rate. But, because of the desirability of these hospitals, it is likely that many of the positions were filled by existing CEOs elsewhere in the hospital industry. Thus, the 18.2% can be reasonably partitioned into a "natural" category—turnover due to retirements, force-outs, etc., which is 11%—and a "ripple effect" category of 7.3%, which is due to the recruitment of other hospital CEOs. An 11% natural turnover rate is not an outrageous one; it corresponds to a tenure of over nine years.

Summary and Discussion

The research reported here lends some insight into the kinds of hospitals that experience high rates of CEO turnover. Turnover in teaching hospitals is highest in non-federal government hospitals, hospitals outside the Midwest, and hospitals in large cities. Higher costs per patient day and low operating margins also characterize the higher-turnover teaching hospitals. The inconsistent relationship between net operating margin and CEO turnover rates in both teaching and nonteaching hospitals suggests that turnover represents factors other than the "bottom line," a finding noted in previous research outside the healthcare sector.[8–10] Nevertheless, the higher-turnover hospitals typically underperformed in profitability relative to the other hospitals studied. Thus, comparison of a hospital's performance with those of others of its type may trigger the CEO's departure.

Of course this secondary analysis of

existing data did not permit us to investigate other potentially more sensitive variables related to CEO turnover. For example, some hospitals have outdated governance and administrative structures that may underlie poor operational performance of these organizations. These hospitals may serve as a "proving ground" to determine which CEOs will be selected by more financially stable institutions. Likewise, the level of executive pay, while related to hospital size, probably provides some independent contribution to explaining CEO turnover.

Despite a comprehensive biographical database on the individual careers of the College-affiliated hospital CEOs, few features distinguished the leavers from the stayers. The most recent data show that the CEOs who are more likely to leave their positions after having served less than the average length of time are unmarried, lack involvement as preceptors to health administration students, have histories of short tenures in previous positions, and reside in states away from their birthplaces. In contrast to historical patterns, these CEOs are not younger than those who do not leave their positions early; they can be of any age group.

While these five variables capture significant differences between the leavers and the stayers, no significant relationships were found to characterize the longer-tenured leavers compared with the stayers. And it is the longer-staying College CEOs who currently experience a higher rate of turnover—17.6% compared with those in their positions for a shorter-than-average time—15.1%.

More precise hypotheses will be studied in the next phase of this research. For example, we plan to examine a sample of CEOs to study their values, working relationships, management styles, and expectations to remain or leave the hospital. Then, a year later, the study will determine who have left their positions, where they went, and why. We expect the observations from such research will allow a better understanding of the causes of turnover. Realistically speaking, however, we know that hospital CEO turnover will always be partly inscrutable. Difficult-to-measure factors such as personal values, organizational culture, ambition, and charisma influence the tenures of hospital CEOs. Moreover, this next phase of the research will not answer the question of whether or not the turnover that occurred brought about positive outcomes for the individual hospital or its community. Additional longitudinal research may help to answer such key questions.

The author thanks C. Thomas Smith for his comments on an earlier version of the manuscript, and John Timmerberg and Lloyd Wackerling for assisting in computer programming.

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